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ABSTRACT

Ten parallel human service agencies (five urban and five rural) were compared to identify variations in the service delivery system and to compare the costs of service provision. The agencies responded to approximately 36 questions covering eight major areas and were compared and contrasted, urban versus rural, according to the type of agency. All of the agencies used some form of basic media advertising but felt more marketing was required. All participated in two or more multi-agency collaborative efforts, with the urban agencies generally involved in more such efforts. Advantages were reduction of duplication and utilization of participating agency strengths. Disadvantages were problems in dealing with conflicting personalities and loss of flexibility and control over programs. All agencies were aware of other services for individuals ineligible for their programs and were satisfied with the number of referrals they made and received. The largest differences were found in their identification of priorities due to service gaps and future plans to address them. (These need areas are discussed in detail in five sections, which compare and contrast the 10 agencies by type of service offered. A table provides information regarding service fees, who determines rates, annual operating budgets, and total revenue generated.) (YLB)

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THE CENTER FOR INDEPENDENT LIVING OF GREATER BRIDGEPORT

Computerized Coordinated Service Center:

A Comparison of Service Methodologies and Costs in the Urban and Rural Area

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INTRODUCTION

The Computerized Coordinated Service Center (CCSC) of the Center for Independent Living of Greater Bridgeport (CILGB), recognizes that there are inherent differences in human service agencies with regard to resources, concerns, and service methodologies in urban and rural communities. In order to investigate and compare these differences, CCSC undertook a survey which compared ten parallel human service agencies (five urban and five rural). The intent of this report is to identify variations in the service delivery system and compare the costs of service provision among the ten parallel agencies. The ten participating agencies and their geographic location can be found in Table 1.

Table 1

AGENCIES SURVEYED

Type of Agency	Urban Agency	Rural Agency
Vocational Rehabilitation Center/Workshop	Parents & Friends of Retarded Citizens, Inc.	DATAHR, Inc.
Information & Referral and Safeguarding Agency	City of Bpt. Office of Handicapped Services	WeCAHR, Inc.
Mental Health After-Care Program	Family Services-Woodfield After-Care Program	Catholic Family Services
Adult Medical Care	Southwest Health Center	Danbury Hospital Adult Medical Clinic
Regional Centers/ Devel. Dis. & Mental Retardation	Ella T. Grasso Regional Center	Danbury Regional Center

The agencies were purposely matched in the rural and urban settings for the following reasons. Often, in a rural setting, a single agency must address many services to meet the diverse needs of individuals living within their geographic areas. We believe that these agencies are therefore more likely to have a greater number of small discrete programs to accommodate consumers with differing disabilities.

Conversely, we believe that urban agencies, since the more dense urban population demands a larger number of service programs, have a greater opportunity to be involved in cooperative and collaborative relationships with neighboring agencies. We suspected that urban agencies could more easily pool resources in providing a comprehensive continuum of services through inter-agency referral. We thought they might provide fewer discrete services to a larger number of persons and engage in more multi-agency collaborative projects since transportation and distance between facilities would present less overwhelming problems than in a rural area. Urban agencies may therefore be able to more easily concentrate their programs in a specific area, and more readily call upon neighboring agencies to provide information or to serve the needs of consumers not eligible for their own services.

The ten agencies were asked to respond to approximately thirty-six questions covering eight major areas. These areas included marketing, advertising and referral sources, multi-agency collaborative efforts, services offered and revenue generated through direct service provision, financial and operating expense information, general administration and program evaluation for major service areas, organizational structure, priorities with respect to service gaps and future projects, and utilization of generic and categorical services. The agencies were compared and contrasted, urban versus rural, according to type of agency.

As the information on all ten agencies was compiled it became apparent the there were a number of trends that could be found in most, if not all, of the agencies. These trends are as follows:

All of the agencies surveyed use some form of basic media advertising, either through Public Service Announcements, brochures, annual reports, and/or newsletters. All of the agencies, however, felt that more marketing was required from themselves and other agencies in order to facilitate public awareness of and exposure to programs currently available in both geographic locations. All of the agencies currently participate in two or more multi-agency collaborative efforts, with the urban agencies generally involved in more of such efforts than the rural ones. Most of the agencies feel that these multi-agency efforts are advantageous in that they reduce duplication of effort and utilize the strengths of all participating agencies, thereby allowing consumers to obtain the best and most comprehensive service available. Most of the agencies stated that multi-agency cooperation also serves to increase both public and agency awareness of existing programs. The major disadvantages of multi-agency collaboration and cooperative efforts cited were related to the problems in dealing with many different and sometimes conflicting personalities as well as the loss of flexibility and control over programs for any one specific agency.

All of the agencies surveyed were aware of other services in their area for those individuals, if any, considered ineligible for their programs. Lastly, all agencies were satisfied with the number of referrals they made out to the community and to neighboring organizations, and were either satisfied with the number of referrals that they received from their communities, or stated that any problems in the area of referrals in or out were a result of the need for more marketing.

The largest differences among all ten agencies were found in their identification of priorities due to service gaps and the future directions and plans which the organizations were making in order to address these priorities. These need areas will be discussed in detail in the following five sections, which compare and contrast the ten agencies by type of service offered. Information regarding service fees, who determines rates, annual operating budgets, and total revenue generated by the surveyed programs can be found in Table 2, in the sixth section of this report.

A. Vocational Rehabilitation/Workshop Program:

DATAHR, Inc. and Parents and Friends of Retarded Citizens, Inc. were the two Vocational Rehabilitation/Workshop programs surveyed. Both of these agencies are primarily Vocational Rehabilitation Centers. Parents & Friends serves primarily mentally retarded persons, while DATAHR serves a more diverse population that includes persons who are mentally retarded as well as persons with many other types of developmental disabilities (DD). Both have respite care and residential facilities as well. DATAHR has recently (October, 1983) added a program for individuals who have sustained a traumatic brain injury (TBI).

As primarily Vocational Rehabilitation programs, these two agencies are extremely similar. Both offer vocational evaluation, work adjustment and work training programs, sheltered employment, and job placement. Both offer a wide range of special and support services including Occupational, Physical, Speech and Language Therapy, Educational, Medical, and Psychological services. Both agencies are funded primarily through the Department of Vocational Rehabilitation (DVR) and the Department of Mental Retardation (DMR), although Parents & Friends relies more heavily on DMR as a funding source, while DATAHR relies more heavily on DVR. The programs differ with respect to size; Parents & Friends has 340 client slots while DATAHR serves about 400 clients per year and can handle can handle 165 clients at any one time, approximately 130 of whom are long-term clients and 35 of whom vary according to program.

Parents & Friends is governed by a thirty member Board of Directors which, although not specifically mandated to include consumers, voluntarily does include ten parents of consumers. DATAHR's forty-five member Board of Trustees, which oversees its long-term plans, is mandated to have at least three consumer members, while DATAHR's eleven member Board of Directors, which oversees more of the daily operations of the program, also has three consumer members although not specifically required in the by-laws to do so.

The major differences between these two organizations are found in their identification of high priority service gaps, and the directions that they plan to pursue in order to alleviate these problems, although there are a few areas where both agreed on priorities for future programs. Parents & Friends identified the population of elderly and severely disabled MR individuals as a high priority need area, and in fact, is looking into comprehensive services to satisfy the needs of this group of individuals. Another priority for Parents & Friends is to establish an intermediate step in vocational training, (i.e. a semi-competitive placement) and the agency is investigating possibilities for this type of placement.

DATAHR proposed that services of all types (residential, vocational, etc.) are needed for persons with psychological disabilities and Parents & Friends agreed that there should be a stronger liaison between the disciplines of Mental Health (MH) and Mental Retardation (MR) in order to provide services for persons with psychological disturbances or individuals who have been dually diagnosed (MH/MR). Both agencies expressed a strong need for more community residences for mentally retarded individuals.

DATAHR, as previously mentioned, introduced a TBI program in October, 1983 and is channeling much effort into this area, as well as into comprehensive services for other groups with special needs post-acute care discharge (e.g. persons with spinal cord injuries and/or stroke). DATAHR identified an urgent need for day programs for these individuals as well.

B. Information & Referral and Safeguarding Agencies:

The City of Bridgeport's Office of Handicapped Services (OHS) and the Western Connecticut Association for the Handicapped and Retarded, Inc. (WeCAHR) were the two Information & Referral (I & R), Safeguarding, and Advocacy agencies surveyed. Both of these organizations serve as community advocates as well as I & R sources for their respective geographic areas. OHS however does offer the added service of technical assistance in areas such as barrier removal. Other than this, they both provide I & R and safeguarding services by a similar, on-demand basis.

In the area of funding sources, obviously, being that one agency (OHS) is a municipal agency and one is a private, non-profit organization (WeCAHR), one would expect funding sources to differ accordingly. OHS does receive funds from the State of Connecticut; the City of Bridgeport, Public Services-Physical Development Department; and from a Social Services Block Grant. Interestingly enough, WeCAHR also receives funds from the city in which it is located (Danbury), although they are not a municipal organization. WeCAHR is also funded through the State of Connecticut, Department of Protection and Advocacy; United Way; and Federal Revenue Sharing. Both organizations also receive some funds through Community Development Block Grants.

Both of these agencies are similar in that they have no restrictions for total number of cases that they handle; as mentioned before, clients are served by an on-demand basis. Both are small agencies with respect

to number of staff (six or less). OHS is guided by the Mayor's Commission on the Handicapped, a group of eighteen which includes both parents of consumers, consumers, and agency heads as members. WeCAHR is governed by an eleven member Board of Directors, which also includes parents of consumers.

The identification of priority areas becomes the main point of diversification for these two agencies, showing more concretely the differences between urban and rural settings. OHS identified the areas of vocational skills training, dollars for Personal Care Attendant programs (and Personal Care Attendants), housing for individuals with mental disabilities, and legal assistance as priority areas. To augment these needs, OHS is looking into a Social Services Block Grant for Personal Care Attendant programs, a program with the University of Bridgeport for legal assistance, and a jobs bill to meet vocational needs.

WeCAHR, on the other hand, identified its greatest priority in the need for more outreach and advocacy due to their large caseload, and the problems that their staff members routinely experience in initiating and maintaining contact with consumers in the often isolated rural areas. WeCAHR also cited problems with transportation and the availability of outreach workers. To address these needs, they plan to hire an additional part-time advocate, beginning in the winter of 1984.

C. Mental Health After-Care Programs:

Family Services-Woodfield's Mental Health After-Care Program (FSW-MHAC) and Catholic Family Services' Transitional Care Program (TCP) were the two Mental Health After-Care programs surveyed. (There is a Catholic Family Services in Bridgeport which was not included in this survey) Both of these programs are targeted for those individuals with psychological disturbances who are at risk of being hospitalized. Both programs provide case management, advocacy, and housing assistance services. Neither program has residences for these individuals, but FSW-MHAC started a volunteer program in October, 1983 whereby individuals (Housing Resource Specialists) are trained to locate homes to suit individual clients' needs.

Both agencies cited United Way and the State Department of Mental Health (DMH) as major third party funders, but in addition, both programs are also supported in part by Medicare, Medicaid, and private insurance companies. Both agencies are governed by Boards of twenty or more members. The Board which governs all of the programs run by Family Services-Woodfield is made up of forty persons, including consumers (although there are no mandates for having consumers on the Board). TCP is governed by the Advisory Board of Catholic Family Services, which is made up of twenty-four members, including various professionals from health care related disciplines (e.g. psychologists, social workers, physicians, etc.). The two agencies are contrasted in terms of staffing; FSW-MHAC having six case managers, one administrator and one secretary; while TCP has a staff of two full-time workers.

Both agencies cited the area of MH as a priority for development, although the two agencies identified some different needs within this discipline. FSW-MHAC cited a lack of volunteers, rehabilitation facilities for chronically ill mentally disabled persons, and the need for hospital emergency room facilities that provide complete psychiatric services as priority areas. To supplement these need areas, FSW-MHAC has applied for a DMH grant to establish a volunteer program, another DMH grant to identify family care home providers and proposes to promote the review and monitoring of DMH community support funds through the Regional MH Board.

TCP identified a strong need for the linkage of individuals in their program to comprehensive care within the community. As previously mentioned, the Advisory Board which governs all of Catholic Family Services is made up of community-based professionals from all related disciplines. To aid consumers in receiving complete care, a new position for a case manager liaison, who must be a Board member, has been created. This individual will serve as a link between the professional services available and the consumers. Both TCP and FSW-MHAC identified the need for transitional and permanent housing facilities for individuals with MH disabilities.

D. Adult Medical Center:

The two adult medical centers surveyed were the Southwest Health Center of Bridgeport (SWHC) and Danbury Hospital Adult Medical Clinic (AMC). Both of these offer a wide variety of out-patient care to individuals needing medical services. (Both organizations offer dental services, also.) The major difference between these two is that SWHC is a federally funded program (through the Dept. of Health and Human Services) designed to provide primary health care to an underserved population and AMC is an out-patient clinic of a large 'suburban' hospital. In keeping with this, SWHC offers care in basic areas such as pediatrics, internal medicine, family planning, and obstetrics/gynecology, while AMC offers care in these areas along with care in a multitude of specialty areas which one can find in many hospital environments (i.e. allergy, arthritis, genetics,...etc.). As already stated, SWHC has federal support, while AMC is funded as a department of Danbury Hospital. Both centers, however, are subsidized through the third party sources of Blue Cross, Blue Shield, Medicare, Medicaid, and private insurance companies.

Another large difference between the two organizations is in the number of clients served, or expected to be served within a one year period. SWHC serves approximately 15,000 individuals per year, while AMC serves about 3,700 in general medical visits and another 5,000 per year through I & R contacts or through the Visiting Nurses Association (VNA). SWHC is governed by a Board made up of consumers and providers, while AMC if governed by the fifteen members of the Board of Directors of Danbury Hospital, which is a subset of the forty-five member Board of Trustees.

Priority areas identified by each of these medical centers differ, as well. SWHC has identified high priority service gaps in the areas of

transportation (door-to-door), identification of physicians who accept Title #19 payment, 24-hour home health care, and pre/post neonatal care. SWHC began a neonatal care program in October, 1983 to address one of these priorities.

Although not directly related to the medical needs of adults, more comprehensive care for pediatric patients with developmental disabilities and individuals who have suffered TBI, as well as endocrine, cardiology, and more primary care programs were the areas identified by AMC. To address some of these need areas, plans are being developed for a follow-up clinic for pediatric developmentally disabled patients, primary pediatric care, and TBI programs. AMC stressed the importance of multi-agency cooperative efforts to prevent such service gaps from occuring and in fact, they frequently cooperate with organizations like the VNA.

E. State Regional Centers:

The two State Regional Centers questioned were the Ella T. Grasso Regional Center (ETGRC) located in Stratford and the Danbury Regional Center (DRC). These agencies are nearly identical in most aspects. Both serve mentally retarded individuals and their families. They both offer services which include residential, group home and community training home placements, respite services, a supervised apartment program, and programs for a special school district, early intervention, and adult activity.

Both centers are presently working with 370 active clients and there is no charge for community services or day programs at either center. However, the majority of the slots at DRC are day placements, while the majority of the 370 slots at ETGRC are for residential clients. Charges for the residential programs offered at both organizations are based upon legislation by the State of Connecticut. Program funding at both locations is obtained through the General Fund of the State of Connecticut. Some special programs may be funded through grants, and there is some contribution obtained at both locations through their communities or through individuals. Both agencies receive third party reimbursement from Title #19, Social Security Insurance, and Boards of Education.

In the area of service gaps and priority needs, however, the two agencies differ somewhat. DRC identifies problems with serving marginally or borderline disabled persons. DRC states that these groups are hard to reach because they often do not wish to initiate contact with DRC and thereby identify themselves with more severely disabled individuals. DRC also identifies the need for programs for juvenile delinquents because, once again, parents, although referred to DRC by their children's schools, do not wish to make contact with DRC. In order to serve another need which is seen as a priority, DRC plans to develop a transitional living program with Fairfield Hills Hospital in order to serve the needs of those who have a dual diagnosis.

ETGRC has identified the population of severely physically disabled and severe and profoundly retarded persons as priorities for service. ETGRC stated that more community placements are needed for severely and

multiply disabled individuals, and ETGRC agreed with DRC in that comprehensive services are needed for individuals with a dual diagnosis. To address some of these service gaps, ETGRC has plans to develop specialized group homes which would be targeted for severely retarded individuals. In order to accomplish this goal, ETGRC is working with Parents & Friends of Retarded Citizens and other local organizations as needed.

E. Fees, Budgets and Revenue:

The fees for all of these services, the parties who determine these fees, the annual budgets and the total amount of revenue generated by the programs offered at all ten agencies can be found on the following page in Table 2.

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Conclusions

Upon completion of the survey and examination of the information obtained through the questionnaire, a number of points became visible.

All of the agencies surveyed identified the need for marketing in order to make existing programs more visible to those individuals in the community who need services and are unaware of what programs are available. This becomes particularly important in the rural area where geographical separation makes it harder to reach disabled individuals. The rural agencies, in particular, identified the need for greater outreach and advocacy in order to better serve individuals in their community. WeCAHR, as of January, 1984, is hoping to have an additional part-time advocate to help address this priority area.

It was also recommended by a rural agency that a 'broker' be established who would act to inform community professionals of services available for disabled individuals with whom they might come into contact. This would aid in linking the individual to the appropriate services necessary for them to achieve a more independent lifestyle.

Another trend which became apparent was that urban agencies were in fact, involved in more cooperative and collaborative efforts than their rural counterparts. This may be due to the higher number of agencies and greater density of population in the urban area. All agencies surveyed were involved in and felt multi-agency efforts to be beneficial to both the agency and consumer. In the rural area, the most predominant multi-agency effort is the Regional Coalition of Agencies Serving the Handicapped (CASH). All of the rural agencies surveyed were involved in some smaller multi-agency efforts, usually involving themselves and one other agency for a specific project, but CASH is presently the largest of these efforts, involving four of the five rural agencies surveyed in addition to other agencies (the four were DATAHR, WeCAHR, DRC, and Danbury Hospital).

TABLE 2: Fees, Budgets and Revenue

	Type of Agency	Vocational Rehabilitation/ Workshop	I & R Safeguarding, and Advocacy	Mental Health After-Care	Adult Medical Care	State Regional Center
URBAN AGENCIES	Name of Agency Surveyed	Parents & Friends of Retarded Citizens, Inc.	City of Bpt. OHS	Family Services-Woodfield MHAC	Southwest Health Clinic	Ella T. Grasso Regional Center
	Service costs/fees	$ 21.66 for vocational services	Free to consumer (Actual cost - $1.50/I & R contact $3.50/Advocacy contact)	Free to consumer	Sliding scale based on family size, income and poverty guidelines	No charge for community and day placements Residential fees determined by state, over 18 yrs. covered by Title 19.
	Determined by whom	Dept. of Income Maintanence	Not applicable	Not applicable	BHCDA formula. (Bureau of Health Care Delivery & Assistance	
	Annual operating budget	$2,100,000	$137,878	Unknown at this time (determined after Jan. 1)	$500,000	Tot. $4,006,815 3,221,737 Personnel 785,078 Operating Expenses
	Total revenue generated by fees	$1,890,000(90% of annual budget)	None	None	approximately 90,000/yr.	Not applicable
RURAL AGENCIES	Name of Agency Surveyed	DATAHR, Inc.	WeCAHR, Inc.	Catholic Family Services TCP	Danbury Hospital Adult Medical Clinic	Danbury Regional Center
	Service costs/fees	$24.46 for vocational training	Sliding fee only for special advocacy, based on income-(Range from $5.00/hr. to $50.00/hr.)	Sliding scale @$44.00/hour	Sliding scale according to need-initial visit $50.00 follow-up $18.00	Same as ETGRC
	Determined by whom	Dept. of Income Maintenance	WeCAHR	Diocese-Social Security Income Fee system	Hospital Cost Commission and Hospital Administrators	Same as ETGRC
	Annual operating budget	approximately $2,000,000	$65,575	$53,500 Total for TCP program only	Out-patient budget Tot. $700,000	Tot. $1,309,126 1,040,160 Personnel 268,966 Operating Expenses
	Total revenue generated by fees	approximately $1,600,000(80% of annual budget)	$300	$65,000 generated by entire CFS program	At least $700,000 to cover costs	Not applicable

In the urban area, there are two programs that were actually created as the result of federal grants awarded to multi-agency collaborative efforts (the Center for Independent Living of Greater Bridgeport (CILGB) and the Human Services Transportation Consortium in Bridgeport). CILGB also heads an Inter-Agency Team which includes the Division of Vocational Rehabilitation, Goodwill Industries, the Office of Handicapped Services, Parents & Friends of Retarded Citizens, the Rehabilitation Center of Eastern Fairfield County, and United Cerebral Palsy. There is a Bridgeport Mayor's Commission on the Handicapped which advises the Office of Handicapped Services, and is made up of the heads of various Bridgeport-based agencies. (There is also a recently started Danbury Mayor's Commission on the Handicapped which is made up of consumers, professionals, families, and friends of consumers, and is aiming to achieve goals similar to the commission in Bridgeport.) All of these multi-agency efforts facilitate a continuum of comprehensive services for urban consumers.

The specific differences and trends among the ten parallel agencies became obvious as they were examined pair by pair, except for the one priority area which all of the agencies agreed upon, which was the need for more community housing for individuals of all disabilities.

Parents & Friends serves an essentially homogeneous population (MR/DD) and identified areas of high priority which were directly related to this population. They are looking into programs which will satisfy the needs of elderly and severely developmentally disabled persons, as well as other previously unserved developmentally disabled persons who are higher functioning. Plans for services for lower and higher functioning persons include community-based housing and employment programs. DATAHR has channeled much effort into the development of a program to serve persons with special needs post-acute care discharge. The initial program developed by DATAHR to serve these needs is a TBI rehabilitation program for individuals who have been discharged from Danbury Hospital's inpatient TBI program. DATAHR is looking into the development of other programs for persons who have sustained strokes or spinal cord injuries to complement and continue progress made by these individuals while hospitalized. DATAHR is beginning to provide services for a previously unserved population rather than broadening the continuum of services to include a wider range of MR/DD persons as Parents & Friends is seeking to do.

The two I & R agencies were greatly similar in respect to services offered. However, the most obvious difference between the two is that WeCAHR is a private, nonprofit agency that is partially supported by the State Department of Protection and Advocacy, and OHS is an established city office. As such, WeCAHR is largely dependent on community support and fundraising efforts in addition to other funding sources. OHS, however, being a municipal office, does not have the same type of survival funding needs. WeCAHR and OHS also differ in identification of high priority areas, with WeCAHR citing one need of the rural community as more outreach and advocacy and OHS citing a number of priorities in the areas of legal assistance, dollars for Personal Care Attendant programs, and vocational skills training.

The two MH After-Care programs were also very similar in respect to services offered. Both agencies also agreed in the identification of housing for chronically ill MH individuals at risk of being hospitalized as a high priority area. However, some differences in the identification of other high priority areas by the two could possibly be due to the difference between an urban and a rural setting.

Family Services-Woodfield identified the need for hospital emergency room facilities that provide complete psychiatric services. The more densely populated urban area may hold a greater number of individuals in need of these services, which makes the lack of adequately equipped emergency rooms a problem in the urban area. Catholic Family Services, however, identified the need for a better liaison system between consumers and professionals in the rural area and has created a special case manager position to serve as the liaison. This need may well have developed from the geographic separation of consumers and professional services available in the rural area.

The contrast between the two adult medical clinics is clearer due to the fact that one is an outpatient department of a large 'suburban' hospital and one is a primary care center in an underserved, lower socioeconomic urban area. The hospital clinic can provide medical care in a multitude of specialty areas in addition to basic primary care, while the urban clinic provides basic pediatric and adult health care, obstetric and gynecological services, and family planning. Obviously, differencs here cannot be attributed only to the contrast between a rural and urban location, but to the difference between a private hospital and a community clinic, as well. In keeping with this, priority areas identified by Danbury Hospital Adult Medical Clinic focused on more services in specialized areas (pediatric developmentally disabled) and priorities at SWHC included door-to-door transportation to and from the facility, 24-hour home health care, and the identification of physicains who accept Title #19 payment.

Lastly, the two State Regional Centers were almost identical with respect to programs offered. The largest difference between the two was caused by DRC's being more of a day placement and ETGRC providing many more residential placements, although DRC does have some residential services. This separation results in a budget for ETGRC which is slightly more than three times that of DRC, even though the rest of the programs offered by both centers and the number of clients served by both are identical.

Once again, priority areas identified by these two agencies differ greatly. DRC identified and is attempting to develop programs for the marginally disabled, juvenile delinquents, and individuals with a dual diagnosis. ETGRC hopes to implement programs which will address the needs of severely disabled individuals (both physically and mentally).

Overall, most of the basic premises concerning the differing trends between and needs of urban versus rural agencies did seem to hold true. Urban agencies did seem to engage in more multi-agency efforts than did their rural counterparts. Rural agencies did seem to feel a greater need for outreach and advocacy due to geographic separation. Beyond this, all of the agencies surveyed identified high priority areas that were specific

to their own communities and were beginning to develop programs which would specifically address those needs. It seems likely that the new programs will serve to provide better and more comprehensive care to individuals in each respective community and therefore help to eliminate some service gaps. This, in turn, should reduce the frustration experienced by those individuals whose needs are not presently being met and provide these individuals with a broader range of options for fuller and more independent lifestyles.